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Supreme Court, U.S.
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No. 93-268

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1993

DIANE M. CUTTING AND WARREN L. CUTTING,
Petitioners,

v.

JEROME FOODS, INC.,
Respondent,

ON PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

RESPONDENT'S BRIEF IN OPPOSITION

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16 pp

COUNTERSTATEMENT OF THE QUESTION PRESENTED

Should the Court reconsider and overrule *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), and adopt a new standard of judicial review of a benefit denial decision by an administrator of a self-funded plan who has been given discretion to interpret the plan and allegedly has a conflict of interest?

RULE 29.1 STATEMENT

Jerome Foods, Inc. has two subsidiaries: Jerome Food FSC, Inc., and Jerome Trucking, Inc. It has no parent company.

TABLE OF CONTENTS

Page

COUNTERSTATEMENT OF THE QUESTION PRESENTED i

RULE 29.1 STATEMENT ii

TABLE OF AUTHORITIES iv

COUNTERSTATEMENT OF THE CASE 1

REASONS FOR DENYING THE WRIT 3

I. The Question Presented was Answered in *Firestone Tire & Rubber Co. v. Bruch* 3

II. There is no Conflict Among the Courts of Appeal to be Resolved 5

III. The Question Presented Involves a Narrow Interpretation of a Provision of a Single Plan and Would be of Little Precedential Effect 8

CONCLUSION 10

TABLE OF AUTHORITIES

Cases Cited: Page

Block v. Pitney Bowes, Inc., 952 F.2d 1450 (D.C. Cir. 1992) 5

Brown v. Blue Cross and Blue Shield of Alabama, Inc., 898 F.2d 1556 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991) 6

Egert v. Connecticut General Life Insurance Co., 900 F.2d 1032 (7th Cir. 1990) 6

FMC Corp. v. Holliday, 498 U.S. 52 (1990) 8, 9

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989) 3-7,9

Fuller v. CBT Corp., 905 F.2d 1055 (7th Cir. 1990) 6

Guy v. Southeastern Iron Workers' Welfare Fund, 877 F.2d 37 (11th Cir. 1989) 7

Hamilton v. Air Jamaica, Ltd., 945 F.2d 74 (3d Cir. 1991), *cert. denied*, 112 S.Ct. 1479 (1992) 8

Lister v. Stark, 942 F.2d 1183 (7th Cir. 1991) 6

McGann v. H&H Music Co., 946 F.2d 401 (5th Cir. 1991), *cert. denied*, 113 S.Ct. 482 (1992) 8

Mertens v. Hewitt Associates, 113 S.Ct. 2063 (1993) 10

Metropolitan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985) 8

Millensifer v. Retirement Plan for Salaried Employees of Cotter Corporation, 968 F.2d 1005 (10th Cir. 1992) 7

Moore v. Metropolitan Life Ins. Co., 856 F.2d 488 (2d Cir. 1988) ... 8

Owens v. Storehouse, Inc., 984 F.2d 394 (11th Cir. 1993) 8

TABLE OF AUTHORITIES

Cases Cited: Page

Rizzo v. Caterpillar, Inc., 914 F.2d 1003 (7th Cir. 1990) 7

Saracco v. Local Union 786 Pension Fund, 942 F.2d 1213 (7th Cir. 1991) 6

Shaw v. Delta Airlines, Inc., 463 U.S. 85 (1983) 8

Van Boxel v. The Journal Company Employees' Pension Trust, 836 F.2d 1048 (7th Cir. 1987) 7

Woolsey v. Marion Laboratories, Inc., 934 F.2d 1452 (10th Cir. 1991) 7

Statutes Cited:

Employee Retirement Income Security Act of 1974 29 U.S.C. §1001 3

Other Authorities Cited:

George Lee Flint, Jr., *ERISA: The Arbitrary and Capricious Rule Under Siege*, 39 Cath. U. L. Rev. 133 (1989) 7

No. 93-268

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1993

DIANE M. CUTTING AND WARREN L. CUTTING,

Petitioners

v.

JEROME FOODS, INC.,

Respondent

On Petition For A Writ Of Certiorari To
The United States Court of Appeals For The Seventh Circuit

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

COUNTERSTATEMENT OF THE CASE

This case involves whether Respondent Jerome Foods Inc. (Respondent) reasonably interpreted its Health Care Plan (Plan) to require Petitioners to sign an agreement to reimburse the Plan from amounts they received from other sources as a condition to receiving Plan benefits.

Petitioner Diane Cutting was injured in an automobile accident on December 25, 1989. Petitioners received $126,000 in settlement from their uninsured motorist carrier and $500,000 from Ford Motor Company on a products liability claim related to the accident. For purposes of the motions below, it was conceded that the settlements did not fully compensate Mrs. Cutting.

Petitioner Warren Cutting is an employee of Respondent, a Wisconsin corporation. Effective January 1, 1990, Mr. Cutting elected to cover Petitioner Diane Cutting, his spouse, under the Plan. The Plan is an employee welfare benefit plan which is self-funded and administered by Respondent. Under the terms of the Plan, "all decisions concerning the interpretation or application" of the Plan are vested in the sole discretion of Respondent as Plan Administrator.

Petitioners submitted medical bills relating to the accident to the Plan. In accordance with the terms of the Plan, prior to paying any medical claims, Respondent required Petitioners to sign an agreement to reimburse the Plan for any amounts that Petitioners received from other sources. The relevant Plan provision provides:

> By accepting any Plan payments of benefits arising out of illness, injury or medical condition, an individual (covered employee or dependent) agrees that the Plan shall be subrogated to all claims, demands, actions and rights of recovery of the individual against any third party or any insurer, including Workers' Compensation, to the extent of any and all payments made or to be made hereunder by the Plan. The Plan shall be entitled to commence an action and try or settle any legal actions it deems necessary in the name of and with the full cooperation of the individual or to intervene in such actions already commenced by an individual and will be reimbursed by the individual to the extent of any amounts paid or payable, past or future, from any third party by way of settlement or in satisfaction of judgment or agreement.
>
> The individual shall execute and deliver any and all instruments and papers requested by the Claim Administrator and shall do whatever is necessary to protect all of the Plan's rights. As a condition precedent to the payments of benefits hereunder, the individual shall, upon written request, execute a reimbursement agreement of the form to be provided by the Claim Administrator or its representative. The individual shall do nothing to prejudice the rights of the Plan to such reimbursement and subrogation and specifically agrees to notify and consult with the Claim Administrator before commencing any legal action concerning claims against any third party or its insurer relating to benefits paid hereunder.

Petitioners refused to sign the agreement and, instead, commenced suit in state court for benefits under the Plan. Respondent removed the case to the United States District Court for the Western District of Wisconsin which granted Respondent's Motion for Summary Judgment. 820 F.Supp. 1146 (W.D.Wisc. 1991). The district court found that the Wisconsin common law of subrogation was preempted by the Employee Income Security Act of 1974 (ERISA), as amended, 29 U.S.C. §1001, *et*

seq. and that ERISA barred the court from creating a federal common law fashioned after Wisconsin's common law. It found further that the Plan granted Respondent the discretion to interpret the Plan and that Respondent's interpretation requiring the execution of the agreement as a condition to benefit payments was not an abuse of discretion. Furthermore, the district court found that the fact that Respondent administered its own Plan did not automatically create a conflict of interest, and that Respondent had not been guilty of bad faith by refusing to pay the claim.

The Court of Appeals affirmed. 993 F.2d 1293 (7th Cir. 1992). On appeal, Petitioners urged adoption as federal common law, a "make whole" subrogation rule which would require that they be fully compensated for all injuries prior to the exercise of any right of subrogation by the Plan. The Court of Appeals concluded that "make whole" subrogation was, at best, an interpretative rule to fill gaps in a plan otherwise silent on subrogation and could be overcome by clear plan language. The Court found it unnecessary to adopt a "make whole" subrogation rule, holding that Respondent's interpretation of the Plan to require the execution of the agreement was reasonable in light of the discretion given to the Administrator to interpret the Plan.

REASONS FOR DENYING THE WRIT

The petition should be denied because the question posed was unanimously resolved by a recent decision of the Court. The Courts of Appeal apply the standard set by the Court and there is no conflict among the circuits on this issue. The case presented applies the well settled standard to the review of the interpretation of a particular document.

I. The Question Presented Was Answered in *Firestone Tire & Rubber Co. v. Bruch*

The question presented in the petition, the standard of review under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, 29 U.S.C. §1001 *et seq.*, of a benefits decision by a plan administrator, was answered by the Court in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). Petitioners argue that where the plan document of a self-funded employee welfare benefit plan gives the administrator discretion to construe plan terms, that decision should be

reviewed by the court under a *de novo* standard if the fiduciary is subject to a potential conflict of interest. *Firestone* expressly rejects this argument.

In *Firestone*, the Court addressed the appropriate standard of judicial review of benefit determinations by fiduciaries and plan administrators under ERISA. In that case, the employer had established benefit plans for which it served as administrator, fiduciary and sole source of funding. 489 U.S. at 105. After Firestone sold five plants as going concerns, six former employees who had been hired by the purchaser, sought severance payments from Firestone. Firestone rejected the severance claims based on its interpretation that the sale of the plants did not constitute a "reduction of the workforce" within the meaning of the severance plan.

The district court granted summary judgment for Firestone holding that it did not act in an arbitrary or capricious manner in denying the severance claims. 640 F. Supp. 519 (E.D.Pa. 1986). The Court of Appeals, noting that Firestone was the plan administrator and that benefits from the unfunded plan came directly from its general assets, declined to use the arbitrary and capricious review standard. Instead, it held that where the employer itself is the fiduciary and administrator of an unfunded benefit plan, deference is unwarranted and its decision to deny benefits should be subject to *de novo* judicial review. (828 F.2d at 137-145).

This Court unanimously rejected this analysis. Applying principles of trust law, the Court distinguished between situations where the plan document vests discretion on the fiduciary or administrator and those which do not. If a fiduciary is given power to construe disputed or doubtful terms, ". . . the trustee's interpretation will not be disturbed if reasonable." (489 U.S. at 111). However, if the document is silent with respect to discretion, the judicial standard of review is *de novo*.

The Court specifically addressed the Court of Appeals' concerns about conflicts of interests as follows (489 U.S. at 115):

> . . . [A] denial of benefits . . . is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. Because we do not rest our decision on the concern for impartiality that guided the Court of Appeals, see 828 F. 2d, at 143-146, we need not distinguish

> between types of plans or focus on the motivations of plan administrators and fiduciaries. Thus . . . the *de novo* standard of review applies whether the plan at issue is funded or unfunded and regardless of whether the administrator or fiduciary is operating under a under a possible or actual conflict of interest. *Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that factor must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.' Restatement (Second) of Trusts §187, Comment d (1959).* (emphasis supplied).

Thus, the appropriate standard of review in cases such as this was unanimously announced by the Court just four years ago.

The *Firestone* standard is clear. Where, as in this case, the plan document gives the plan administrator discretion to interpret the plan, any conflict of interest shall be considered as a factor in determining whether there has been an abuse of discretion. Petitioners seek to have the Court reconsider and reverse *Firestone*. The petition urges, in effect, that the Court now accept the holding of the Court of Appeals in *Firestone* that all potential or actual conflicts of interest be reviewed *de novo* — a holding the Court specifically rejected in that case.

The petition offers no sufficient reason why the Court should reconsider this question and overrule its recent decision in *Firestone*. The petition should be denied.

II. There Is No Conflict Among The Courts of Appeal to Be Resolved

The petition suggests that certiorari be granted because of alleged conflicts among the Seventh, Tenth and Eleventh Circuits concerning the appropriate standard of review in ERISA benefit denial cases. An examination of the cases cited by Petitioners shows there is no conflict among the circuits requiring resolution by the Court.

Petitioners refer to immaterial verbal differences in the formulation, not the application, of the standard. The petition seeks to exalt distinctions without differences. Justice Ginsburg, then writing for the Court of Appeals for the District of Columbia Circuit in *Block v. Pitney Bowes, Inc.*, 952 F.2d 1450, 1454 (D.C. Cir. 1992), explained the fallacy of petitioners' argument concerning different statements of the review standard:

> Some post-*Firestone* decisions, dealing with plans that "give[ ] the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan, " see id. at 115, 109 S.Ct. at 956, speak dominantly of judicial control for "abuse of discretion." See, e.g., *Jones v. Laborers Health & Welfare Trust Fund*, 906 F.2d 480, 481 (9th Cir. 1990); *DeWitt v. A State Farm Ins. Cos. Ret. Plan*, 905 F.2d 798, 800 (4th Cir. 1990). Other decisions invoke the "arbitrary and capricious" formulation. See, e.g., *Exbom*, 900 F.2d at 1141-42; *Lakey v. Remington Arms Co.*, 874 F.2d 541, 544 (8th Cir. 1989). In view of the Supreme Court's alternating references, these lower court formulations seem to us unremarkable.
>
> The distinction, if any, between "arbitrary and capricious review" and review for "abuse of discretion" is subtle. Cf. *Ass'n of Data Processing Service Organizations, Inc. v. Board of Governors of Federal Reserve System*, 745 F.2d 677, 684 (D.C.Cir. 1984) (Scalia, J.) (distinction between substantial evidence test and arbitrary or capricious test is " 'largely semantic' ") (citations omitted). In the matter at hand we are satisfied, there is no need to adopt one phrase and avoid the other. The reasonableness of the Plan Committee's decision is our polestar. . . .

There is no conflict between the standard of review applied in the Seventh, Tenth and Eleventh Circuits. Each Circuit accepts and properly applies the standard announced by the Court in *Firestone*.

In cases where the plan document gives the plan administrator discretion to interpret the plan, the Seventh Circuit has upheld the decision if reasonable. *Lister v. Stark*, 942 F.2d 1183 (7th Cir. 1991); *Saracco v. Local Union 786 Pension Fund*, 942 F.2d 1213 (7th Cir. 1991).

The Eleventh Circuit has equated the abuse of discretion standard with the "arbitrary and capricious" standard in its post-*Firestone* cases. *Brown v. Blue Cross and Blue Shield of Alabama, Inc.*, 898 F.2d 1556, n.1 (11th Cir. 1990) *cert. denied*, 498 U.S. 1040 (1991). The Seventh Circuit has described this difference in terminology not as one of substance, but as splitting semantic hairs (*Lister v. Stark, supra*, 942 F.2d at 1188), and has cited *Brown* with approval. *Fuller v. CBT Corp.*, 905 F.2d 1055, 1058 (7th Cir. 1990). The Seventh Circuit has itself also used the "arbitrary and capricious" formulation. *Egert v. Connecticut General Life Insurance Co.*, 900 F.2d 1032 (7th Cir. 1990); *Saracco, supra*, 942

F.2d at 1214. Regardless of the label, the Eleventh Circuit will uphold benefit denial decisions if the interpretation ". . . was made rationally and in good faith — not whether it was right." *Guy v. Southeastern Iron Workers' Welfare Fund*, 877 F.2d 37, 39 (11th Cir. 1989). This standard is indistinguishable from the standard of "reasonableness" used by the Seventh Circuit.

The Tenth Circuit also utilizes the "arbitrary and capricious" standard in reviewing decisions of an administrator vested with discretion to construe a plan. However, the Tenth Circuit also focuses on the reasonableness of the decision. In *Woolsey v. Marion Laboratories, Inc.*, 934 F.2d 1452, 1457 (10th Cir. 1991), the Court of Appeals framed the applicable standard in words virtually identical to those of the other circuit courts: ". . . we must now determine if the Administrators' reasons for denying [the] request were so insufficient or unreasonable as to be arbitrary and capricious." *See also Millensifer v. Retirement Plan for Salaried Employees of Cotter Corporation*, 968 F.2d 1005, 1009 (10th Cir. 1992) (where two interpretations are rational, ". . . we must defer to the retirement committee's reasonable construction absent administrative bias").

The petition argues that in this case the Seventh Circuit ignored possible conflicts of interest. That assertion is belied by the Court of Appeals' explicit discussion of conflicts and of this Court's decision in *Firestone* in this case (4a-5a), as well its concern about the issue as early as *Van Boxel v. The Journal Company Employees' Pension Trust*, 836 F.2d 1048 (7th Cir. 1987), which is cited by the Court in *Firestone*. *See also Rizzo v. Caterpillar, Inc.*, 914 F.2d 1003, fn. 2 (1990).

Finally, Petitioners rely upon a law review article, George Lee Flint, Jr., *ERISA: The Arbitrary and Capricious Rule Under Siege*, 39 Cath. U. L. Rev. 133 (1989) as a primary reason for the Court to grant certiorari. Flint argues that the proper standard of review in conflict of interest cases should be the *de novo* review standard. The author simply disagrees with the Court's resolution of the issue in *Firestone*, and appears to favor the discredited approach adopted by the Court of Appeals in that case. A single commentator's disagreement with the Court hardly provides a sufficient reason for granting the petition. The position advanced is simply a rehash of an argument the Court has considered and rejected.

There is no Circuit conflict requiring review by the Court. Each Circuit follows *Firestone*, and reviews benefit denials to see whether the decision was reasonable when deference to an administrator is required

by plan language. That is exactly what the Court of Appeals did in this case. Review of that decision is unwarranted.

III. The Question Presented Involves a Narrow Interpretation of a Provision of a Single Plan and Would Be of Little Precedential Effect

The narrow question presented is not sufficiently important to warrant the Court's attention. The case simply involves whether this Plan administrator's interpretation of the provisions of this particular Plan was reasonable in requiring, as a condition of payment, reimbursement from settlement proceeds before a claimant was made whole. Not only is the issue a narrow one, but it was decided correctly below.

ERISA does not mandate that employers provide any particular benefits. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 91 (1983). The Act ". . . does not regulate the substantive content of welfare-benefit plans." *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 732 (1985).

> Instead, Congress intended employers to be free to create, modify, or terminate the terms and conditions of employee welfare benefit plans as inflation, changes in medical practice and technology, and the costs of treatment dictate.

Owens v. Storehouse, Inc., 984 F.2d 394, 398 (11th Cir. 1993); *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988). Instead, ERISA regulates the administration, disclosure and reporting of benefit plans and protects beneficiaries by making sure they receive the benefits that have been promised to them in writing. *McGann v. H&H Music Co.*, 946 F.2d 401, 407 (5th Cir. 1991), *cert. denied*, 113 S.Ct. 482 (1992); *Hamilton v. Air Jamaica, Ltd.*, 945 F.2d 74, 78 (3d Cir. 1991), *cert. denied*, 112 S.Ct. 1479 (1992).

Recognizing that the welfare benefit plan at issue is self-funded and that under *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), all state subrogation laws are preempted by ERISA, petitioners have urged that the "make whole" rule of subrogation be applied to self-funded plans as federal common law. Under this regime, all self-funded plans would be required to refrain from reimbursement from third-party proceeds unless and until the claimant was made whole for any injuries sustained.

The district court rejected this position. It held that the reasoning of *FMC Corp.* ". . . appears to preclude any federal common law that would alter the terms of a written employee benefit plan." (21a). The court expressly rejected claims that the administrator acted in bad faith in his interpretation of the Plan. (26a).

Although adopting a different approach, the Court of Appeals also viewed the issue as ultimately one of how this particular welfare Plan was designed and interpreted. Writing for a unanimous panel, Judge Posner noted that the rule of subrogation urged by petitioners is not a substantive requirement, but a rule of interpretation. He states that "[i]t is difficult to say whether the 'make whole' interpretative principle is predominant, let alone universal." (7a). "The right exists only when the parties are silent. It is a gap filler." (7a). The court then discussed whether a "make whole" subrogation rule was advisable. (7a-11a). Judge Posner concluded (11a):

> Fortunately we need not attempt to decide in this case whether the merits of the rule are sufficient on balance to warrant its use as a principle of interpretation of ERISA plans. Because, as the Cuttings concede, the make-whole rule is just a principle of interpretation, it can be overridden by clear language in the plan.

The Court then addressed the narrow issue of whether this Plan, as drafted, required petitioners to execute a subrogation agreement prior to receiving benefits. The Plan gives the administrator the discretion to interpret its provisions. (3a). The court noted (11a):

> The plan document does state rather flatly that the plan shall be subrogated to 'all claims' by the covered individual against a third party to the extent of 'any and all payments' made (or to be made) by the plan.

Applying the *Firestone* standard, Judge Posner concluded that the company's interpretation of the Plan was not unreasonable in concluding that the Plan had disclaimed any obligation to make petitioners whole.

ERISA permits an employer to design its benefit plans free of interference and requires that such plans be adhered to as written. The Court established the standard of judicial review of benefit denial cases in *Firestone*. This case presents nothing more than a routine application of that well-settled standard to a particular set of facts under the provi-

sions of this Plan. There is no adequate reason for the Court to review this case. Even if petitioners would have been entitled to "make whole" subrogation under pre-ERISA law, as the Court noted last session, ERISA is ". . . an enormously complex and detailed statute that resolved innumerable disputes between powerful competing interests — not all in favor of potential plaintiffs." *Mertens v. Hewitt Associates*, 113 S.Ct. 2063, 2071 (1993). Under these circumstances, this case is not sufficiently important to warrant review.

CONCLUSION

For these reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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